

PRIVACY, HIV/AIDS AND PUBLIC HEALTH INTERVENTIONS

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I. INTRODUCTION

Although HIV/AIDS has claimed centre stage in public and political debates over the last few years, South African scholars largely refrain from examining and discussing the right to privacy and its limitations in the context of HIV/AIDS. Until the Constitutional Court's decision in *NM and Others v Smith and Others*,¹ the lack of literature was accompanied by a scarcity of case law regarding the importance of the protection of privacy of HIV-infected people. This article aims to set the scene for a debate on HIV/AIDS and privacy: the scope of the right, its importance for HIV-infected individuals and the justifiability of limitations in the form of public health interventions.

As an introduction to the subject matter, the first part of this article provides a brief overview of academic discussion around the right to privacy. The article examines the scope of the right and its distinction from other human rights, before assessing its importance for people living with HIV/AIDS. Although both the common law and constitutional law protect privacy, concerns are raised as to whether the legal mechanisms are sufficient to truly protect HIV-infected individuals.

The second part of the article focuses on public health interventions that limit the right to privacy, and thoroughly analyses their implications. First, current health guidelines on HIV disclosure by health care professionals are reviewed, and, drawing on comparative health policies, it is debated whether partner notification programmes should be introduced in South Africa. Interesting questions around the justifiability of invasions of privacy and health care professionals' legal duty to warn patients' partners are discussed.

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¹ *NM and Others v Smith and Others* 2007 (5) SA 250 (CC). The decision is hereafter referred to as *NM and Others v Smith*.

The article then looks at HIV disclosures envisaged by recent legislative developments. The Criminal Law (Sexual Offences and Related Matters) Amendment Act² makes provision for the compulsory HIV testing of alleged sexual and other offenders. The article undertakes a thorough examination of these statutory provisions and raises serious questions in relation to their justifiability.

II. PART I: THE RIGHT TO PRIVACY

The first part of this article serves as an introduction to — rather than a comprehensive discussion of — the right to privacy. Despite its protection under the legal framework, research as well as case law provides us with practical examples of infringements of privacy of HIV-infected individuals. It will be shown that violations of privacy often imply adverse effects on other rights like dignity and equality.

1. THE SCOPE OF THE RIGHT TO PRIVACY

The right to privacy is preserved by both the common law and constitutional law (s 14 Constitution).³ As academic literature demonstrates considerable controversy over the scope, definition and distinction of privacy from other human rights, the article briefly reflects on the concept of privacy.

(a) *Common law v constitutional law*

(1) *Common law*

The common law recognises the right to privacy as an independent personality right that is part of the concept of ‘dignitas’.⁴ According to the common law, the breach of a person’s privacy constitutes an iniuria. For this iniuria to occur, the following elements must be proved: (1) an invasion of privacy; (2) wrongfulness; and (3) fault.⁵ An invasion of privacy can occur by intrusion into or publication of private facts.⁶ The second element, wrongfulness or unlawfulness, is judged by the contemporary boni mores of

² Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

³ These two branches of law serve different purposes. The objective of the common law is to regulate relationships between private parties. Hence, the purpose of a delictual remedy based on the common law is to offer compensation for a suffered harm. Constitutional law, on the other hand, aims primarily at protecting human rights from intrusion of the state; see *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) at para 17.

⁴ *Bernstein v Bester* NO 1996 (2) SA 751 (CC) at para 68 citing *O’Keeffe v Argus Printing and Publishing Co Ltd* 1954 (3) SA 244 (C) 247F–249D and *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1979 (1) SA 441 (A) 455H–456H.

⁵ David McQuoid-Mason ‘Invasion of privacy: common law v constitutional delict — does it make a difference?’ (2000) *Acta Juridica* 229.

⁶ The term ‘private facts’ will be defined under II.1.b. Violations of privacy will be discussed in more detail under II.2.b.

society and may also be influenced by statute law.⁷ Fault, the third component of an iniuria, is required in the form of intention.⁸

(2) *Constitutional law*

Under the Constitution,⁹ a two-stage analysis must be employed in deciding whether the right to privacy was violated. First, the scope of the right must be assessed to determine whether it has been infringed. If it is established that the right has been violated, this violation will *prima facie* be regarded as unlawful. It is then up to the person or body breaching the right to show that the infringement was justifiable (second stage of the analysis).¹⁰ Other than a delictual invasion, the breach of a constitutional right does not require fault.¹¹

(3) *Relationship between the common law and constitutional law*

There has been some debate about the relationship between the common law and the constitutional law of privacy. Ngwena¹² sees an advantage of the constitutional right in its broader scope and applicability. However, his understanding contradicts s 39(2) of the Constitution, which stipulates that the courts must interpret the common law in light of the Constitution. Burchell¹³ rightly argues that the constitutional right to privacy 'will serve to provide substance to any definition of privacy under the common law'.

⁷ The *boni mores* test is an objective test that balances the relevant conduct against the values as well as the general sense of justice in society. Accordingly, the conduct will not be deemed unlawful unless a person of ordinary sensibilities would have regarded the conduct as offensive; see McQuoid-Mason op cit note 5 at 232; Ian Currie/Johan de Waal *The Bill of Rights Handbook* 5 ed (2005) § 14 at 316.

⁸ Intention is the subjective will to injure the plaintiff, including knowledge of the wrongfulness of the act. J Neethling/JM Potgieter/PJ Visser *Law of Delict* 5 ed (2006) § 4 at 112. Such intention and knowledge are presumed unless proven otherwise. *Kidson v SA Associated Newspapers Ltd* 1957 (3) SA 461 (W) at 1213. McQuoid-Mason argues that where the violation of privacy stems from a publication by the media, negligent conduct is sufficient. See McQuoid-Mason op cit note 5 at 229; 234. This view was shared in the minority judgments of Langa J and O'Regan J in *NM and Others v Smith* supra note 1 para 94; 177–178.

⁹ The Constitution of the Republic of South Africa, 1996 (hereafter: the Constitution).

¹⁰ Currie/De Waal op cit note 7 at 317; McQuoid-Mason op cit note 5 at 246. The terms and conditions under which an infringement will be considered justified are set out in s 36 of the Constitution: the limitation clause. This clause states that a constitutional right may be limited only in terms of a law of general application and to an extent that is reasonable and justifiable in an open and democratic society. In establishing whether this is the case, the nature of both the right and the limitation, as well as the purpose of the limitation and the availability of less restrictive means, need to be considered (s 36 (1) of the Constitution).

¹¹ McQuoid-Mason op cit note 5 at 245.

¹² Charles Ngwena 'HIV in the Workplace: protecting rights to equality and privacy' (1999) 15 *South African Journal on Human Rights* 513 at 536.

¹³ Jonathan M Burchell *Personality Rights and Freedom of Expression: The Modern Actio Iniuriarum* (1998) at 395.

McQuoid-Mason¹⁴ asks the valid question ‘common law v constitutional delict — does it make a difference?’ After deconstructing the factors that have been adduced as the differences between the two, McQuoid-Mason concludes that ‘many of the so-called distinctions between a “private law” delict [. . .] and a “public law” delict [. . .] are more apparent than real’.¹⁵ It should be noted that one strong distinction is that the common law delict is fault-based, whereas the constitutional delict is not.¹⁶ Accordingly, it remains interesting to see whether the courts will accommodate delictual actions from constitutional breaches of privacy under the common law and if yes, how this will influence the development of the law of delict.¹⁷ It is, however, neither the focus nor within the scope of this article to discuss this matter further.¹⁸

(b) *Defining privacy*

Although the common law and constitutional law have the same understanding of privacy, there is still some controversy around the definition. Part of the problem is that legal scholars and courts at times use the term ‘private’ to describe what is protected under the right to privacy.¹⁹ This is not only tautological, but also unhelpful in assessing the meaning of privacy because the word ‘private’ can be used in a number of ways.²⁰

Jurisprudential interpretations often remain vague when defining privacy.²¹ In *Bernstein v Bester*²² the Constitutional Court held that ‘there is a

¹⁴ McQuoid-Mason op cit note 5.

¹⁵ McQuoid-Mason op cit note 5 at 246.

¹⁶ See note 11 above.

¹⁷ McQuoid-Mason op cit note 5 at 259, 260.

¹⁸ For further discussion see McQuoid-Mason op cit note 5.

¹⁹ J Neethling ‘The Concept of Privacy in South African Law’ (2005) 122 (1) *South African Law Journal* 20, ‘This condition embraces all those personal facts [. . .] of which he has the will that they be kept private’. McQuoid-Mason speaks of ‘intrusions into a person’s private life or affairs, or aspects of his or her “inner sanctum”’ and, drawing on case law, he lists ‘reading of private documents [. . .]; listening to private telephone conversations’ as intrusions of privacy without clarifying why the courts have considered these documents and telephone conversations respectively to be considered ‘private’. McQuoid-Mason op cit note 5 at 230. Ngwena, while highlighting the inter-relation to other values, also refrains from concretising what privacy means. He submits that privacy ‘serves to protect the individual’s dignity and personality by proscribing unjustifiable intrusions into the private sphere’. Ngwena op cit note 12 at 533.

²⁰ The word can, for example, be used in a solely descriptive sense, meaning that something is ‘private’ because no one knows it other than the person that the information is about (during the first months of a woman’s pregnancy no one knows that she is pregnant unless she discloses this information). The term ‘private’ can also be employed in a normative sense, in that something is not necessarily unknown to others, but should be kept unknown or treated as confidential due to the nature of the information. Yet again, customary and religious norms may require something to be ‘private’.

²¹ See for example *Bernstein v Bester NO* where the Constitutional Court held the position that a legitimate expectation of privacy has two components: (1) a subjective

final untouchable sphere of human freedom [. . .] But this most intimate score is narrowly construed'. Ackermann J reduced privacy to 'the inner sanctum of a person, such as his or her family life, sexual preference and home environment'.²³ More recently the Constitutional Court, drawing on *National Media Ltd and Another v Jooste*,²⁴ defined 'private facts' as affairs 'the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence [. . .] and in respect of which there is a will to keep them private'.²⁵ Neethling,²⁶ objecting that the standard cannot be the '(objective) reaction of a person of ordinary feelings', insists that the subjective perception of the person himself determines the scope of his interest in privacy. He describes privacy as 'a condition of human life characterized by seclusion from the public' embracing all the facts that a person has 'himself determined to be excluded from the knowledge of outsiders'.²⁷ The fact that the expectation of privacy must be objectively reasonable is only considered under the element of wrongfulness.²⁸ As a result, one can make the argument that privacy does not only protect truly intimate spheres such as family life, home environment and sexuality, but also extends to personal matters that are not necessarily of an intimate nature, but that a person wishes to keep out of the public domain for other legitimate reasons.

The protection of privacy also extends to the area of data-collection 'where the information collected about a person is often not of a most personal nature, or some of the data, taken on their own, may not even be private, [. . .] but the total picture thereof is usually of such a nature that the person concerned determines [. . .] the data to be private'.²⁹ Accordingly, another aspect of the right to privacy is 'informational privacy', which

expectation of privacy that (2) the society has recognised as objectively reasonable. Despite its limited practicability, the definition of the Constitutional Court highlights the fact that the principles of 'reasonableness' and 'the ordinary person' play an important role in determining the scope of privacy. *Bernstein v Bester NO* supra note 4 para 75.

²² Ibid para 77.

²³ Ibid para 67. Ackermann J's definition was however not followed in the decision *Hyundai Motor Distributors (Pty) Ltd v Smit NO* 2001 (1) SA 545 (CC) 557.

²⁴ *National Media Ltd and Another v Jooste* 1996 (3) SA 262 (A).

²⁵ *NM and Others v Smith* supra note 1 para 34.

²⁶ J Neethling 'The Right to Privacy, HIV/AIDS and Media Defendants' (2008) 125 *South African Law Journal* 36 at 38.

²⁷ Neethling op cit note 19 at 19.

²⁸ *Hyundai Motor Distributors (Pty) Ltd v Smit NO* supra note 23 at 557.

²⁹ Neethling op cit note 19 at 20. For example, an e-mail address taken on its own is not considered as intimate information, because it is used for business and social affairs. But together with other data (eg all the information that a user enters into a profile for an online shop) the information must be considered private if that is the determination of the individual.

restricts 'the collection, use of and disclosure of personal information that has been collected by others'.³⁰

Over the last decades the compilation, processing and dissemination of data has been fundamentally facilitated and advanced through electronic technologies.³¹ The South African Law Reform Commission (hereafter: SALRC) has recognised that these technologies increase the need for effective data protection and has therefore suggested new statutory legislation that regulates the processing of data by public and private bodies. The proposed 'Protection of Personal Information Bill' (hereafter: POPIB) received a large volume of comments, which are currently reviewed by the Law Reform Commission.³²

Under the POPIB, the standard for processing health information is stricter than the standard for other information.³³ The processing of health information is generally prohibited (s 24 POPIB). Section 29 POPIB, however, sets out circumstances in which the prohibition does not apply. Medical professionals, health care institutions or facilities, or social services, for instance, may process health information (s 29(1)(a) POPIB). Although the proposed POPIB seems to be generally supported for bringing South African legislation in line with international standards, for providing 'an omnibus data protection Act'³⁴ as well as for balancing the interests between privacy and access to information, the implications of the legislation are at this stage unclear. The Bill has not yet been introduced into Parliament. Experience shows that in the course of parliamentary deliberations a proposed statute may change considerably. Given that the format of the

³⁰ Currie/De Waal op cit note 7 § 14 at 323. The challenges of privacy in the area of data protection were comprehensively discussed in the decision of the Constitutional Court in *Mistry v Interim National Medical and Dental Council of South Africa* where the Constitutional Court considered the following facts relevant to establish whether certain data qualified as private: whether the information was obtained in an intrusive manner; whether the information was about intimate aspects of the applicant's personal life; whether the applicant provided the data for one purpose but it was used for another and whether the information was disseminated to the press or the general public or persons from whom the applicant could reasonably expect such private information would be withheld. *Mistry v Interim National Medical and Dental Council of South Africa* 1998 (4) SA 1127 (CC) at para 51.

³¹ For more detail see Anneliese Roos 'Data Protection: Explaining the International Backdrop and Evaluating the Current South African Position' (2007) 124 *South African Law Journal* 400 at 401.

³² Kate Allan/Iain Currie 'Enforcing Access to Information and Privacy Rights: Evaluating Proposals for an Information Protection Regulator for South Africa' (2007) 23 *South African Journal of Human Rights* 570. SALRC (2005) *Privacy and Data Protection*, Discussion Paper 109, Annex B, available at <http://www.doj.gov.za/salrc/dpapers.htm> (last accessed 14 October 2008).

³³ Generally, information has to be processed 'in accordance with the law and in a proper and careful manner in order not to intrude upon the privacy of the data subject to an unreasonable extent' (s 7 POPIB).

³⁴ Roos op cit note 31 at 406; 433; Allan/Currie op cit note 32 at 586.

(final) legislation as well as its enactment are uncertain, the draft legislation will not be discussed in more detail.

(c) *Confidentiality*

One aspect of privacy is confidentiality. The existence of a special relationship between two parties can render information disclosed between such parties confidential, whereas the same information would not be considered confidential had it been exchanged outside of such a relationship. The law, in certain circumstances, recognises confidential relationships between parties and protects the information shared between them under the right to privacy. Special relationships may exist inter alia between a religious figure and a member of the congregation,³⁵ an attorney and his client,³⁶ the police and their informant³⁷ and a doctor and his patient.³⁸ The reason for considering their exchange of information as confidential stems from the nature of the parties' relationship marked by trust and a justifiable expectation that the information exchanged between them will not be shared with others.

The relationship between doctors and patients is particularly relevant for the forthcoming discussions. Confidentiality forms the basis of the special relationship between a patient and a health care professional (hereafter: HCP³⁹). The principle of confidentiality states that a person should be entitled to privacy with regard to his most personal physical and psychological conditions.⁴⁰ Medical confidentiality therefore casts a duty upon HCPs to keep secret and confidential any and all information relating to a patient that has been obtained directly or indirectly as a result of the HCP-patient relationship.

However, there are significant conceptual differences between the right to privacy and confidentiality. The right to privacy can be invoked directly to prevent the government or any person from gaining access to personal information and to hold them legally accountable if they have gained access improperly. Confidentiality on the other hand only binds certain individuals, in this case HCPs, and has, until the recent enactment of the National Health

³⁵ *O v O* 1995 (4) SA 482 (W) 490.

³⁶ Conversations between a lawyer and his or her client are furthermore protected by the legal professional privilege. Communications between the two cannot be disclosed in court without the client's consent. See PJ Schwikkard/S E Van der Merwe *Principles of Evidence* 2 ed (2002) § 10 at 134.

³⁷ *Swanepol v Minister van Veiligheid en Sekuriteit* 1999 (4) SA 549 (T).

³⁸ *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A).

³⁹ The term 'health care professional' is used as a general term for doctors and nurses dealing with patients in a health care facility or setting. It refers to male and female persons.

⁴⁰ Jerold L Taitz *Medical Confidentiality and the Law in South Africa* (1990) at 1 as quoted in Jerold L Taitz 'AIDS Patients Are Entitled To The Right Of Medical Confidentiality' (1992) 8 *South African Journal on Human Rights* 577.

Act⁴¹ (hereafter: NHA), only encompassed an ethical duty.⁴² In order to strengthen patients' rights, the NHA upgrades the ethical principle of confidentiality to a binding statutory principle and clarifies that informed consent is required for health services such as HIV tests.⁴³ In addition to the NHA, guidelines of various professional bodies, some of which are HIV-specific,⁴⁴ require HCPs to keep patients' health information confidential. The guidelines of the Health Professions Council of South Africa (hereafter: HPCSA), for instance, state that the test results of HIV-positive

⁴¹ National Health Act 61 of 2003. The NHA is a comprehensive piece of medical legislation that applies to both public and private health care facilities. It entails detailed provisions for the protection of confidentiality, emphasising that *all* information concerning a user of a health facility, including information relating to his or her health status, treatment or stay in a health establishment is confidential (s 14 NHA). Confidential information may be disclosed only with the patient's informed consent in writing (s 14(2) NHA). The legislation does however allow breaches of confidentiality in certain circumstances. If, for instance, a court order or any law requires the disclosure of specific health information, the consent of the patient is not required for such disclosure (s 14(2) NHA). Consent is furthermore essential for the provision of health services. Health services may not be provided to a patient without his or her informed consent (s 7(1) NHA). For consent to be valid, the person giving such consent must be legally competent to do so, must clearly understand the implications of the consent and must have adequate information to make an informed decision without coercion or threat; See G J Knobel (2006) 'Consent, with particular reference to HIV and AIDS' (2006) 24 *South Africa's Continuing Medical Education Monthly* 79. It should be noted that the NHA also provides for exceptions from the principle of informed consent; as these principles are irrelevant to this article they will not be further discussed.

⁴² Generally, non-compliance with an ethical duty or a duty under a policy does not *per se* constitute an act that is legally actionable but may result in disciplinary measures by the relevant oversight body of the profession. A policy breach *may* however provide grounds for a claim; see *Jansen van Vuuren and Another NNO v Kruger* supra note 38 at 850E–F.

⁴³ See s 7 NHA. However, certain aspects of the provisions regarding confidentiality remain problematic. Whereas it may be appropriate to waive the patient's consent if a court order requires the disclosure of medical information, it seems alarming that the legislation allows HCPs to disclose confidential medical information 'to any other person [. . .] or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user' (s 15(1) NHA). The legislation is unclear about who decides what a legitimate purpose is, what is 'within the ordinary course and scope' of the HCP's duties, and what is 'in the interest of the user'. Discretion of the HCP may entail insecurity and risks for the patient. One apprehension is that an HCP might think that a disclosure of the patient's disease is necessary for other HCPs treating the patient, assuming that such warning of colleagues might also be in the interest of the patient. The principle of informed consent had been recognised by the common law in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) and *Castell v De Greef* 1994 (4) SA 408 (C).

⁴⁴ Health Professions Council of South Africa 'Guidelines for the Management of Patients with HIV or AIDS' (n.d.). The South African Medical Association, a professional organisation for public and private sector medical practitioners, developed the Human Rights and Ethical Guidelines on HIV and AIDS.

patients should be treated 'at the highest level of confidentiality'.⁴⁵ Aspects of these guidelines will be discussed in more detail below.⁴⁶

(d) *Distinction from other rights*

Privacy is closely related to other human rights and personality interests. In *NM and Others v Smith and Others* O'Regan J characterises 'privacy, liberty and dignity as the key constitutional rights which construct our understanding of what it means to be a human being'.⁴⁷ It has been said that the right to privacy protects a 'sphere of intimacy and autonomy'⁴⁸, it 'foster[s] human dignity'.⁴⁹ A core value served by privacy is thus dignity.⁵⁰

Whether there has been a violation of privacy is, however, in no way dependent on whether there has been an infringement of dignity. Most scholars agree that privacy is an interest independent from dignity under both the common law and the constitutional law.⁵¹ In many instances of invasion of privacy there is, in fact, no question of having harmed a person's dignity; for example, where laudable personal facts are published contrary to the will and desire of the victim.⁵² The right to privacy guarantees control over *all* private information and, contrary to dignity, a violation of privacy does not require information to be potentially damaging.⁵³

According to Neethling,⁵⁴ privacy must also be distinguished from the right to identity. He opines that privacy — being a condition of life characterised by seclusion from publicity — can be infringed only through a disclosure of *true* private facts.⁵⁵ Identity — a person's uniqueness — on the other hand, can only be violated by a falsification of his true image.⁵⁶

Other scholars⁵⁷ reject the existence of an independent right to identity

⁴⁵ HPCSA *Guidelines for the Management of Patients with HIV or AIDS* (n.d.) at 10.1.

⁴⁶ See III.2.

⁴⁷ *NM and Others v Smith* supra note 1 para 131.

⁴⁸ Neethling op cit note 19 at 23.

⁴⁹ *Hyundai Motor Distributors (Pty) Ltd v Smit NO* supra note 23 at 557.

⁵⁰ Dignity is protected by the constitutional law (s 10 Constitution) and the common law. Neethling et al op cit note 8 § 10 at 321.

⁵¹ See Neethling op cit note 19 at 23; Neethling et al op cit note 8 § 10 at 322; Currie/De Waal op cit 7 § 14 at 316; McQuoid-Mason op cit note 5 at 229. This assumption is confirmed by the separate provisions for privacy (s 14 of the Constitution) and dignity (s 10 of the Constitution) in the Constitution. McQuoid-Mason however adds that the strict distinction is only a tool to classify various forms of invasions of privacy under an action for an iniuria.

⁵² Neethling op cit note 19 at 23.

⁵³ Currie/De Waal op cit 7 § 14 at 323.

⁵⁴ Neethling op cit note 19 at 24; Neethling et al op cit note 8 § 10 at 324.

⁵⁵ In a case of infringement of privacy, the name, likeness or other personal characteristics which identify the person in question are used in a (truthful) manner exclusive to him; Neethling op cit note 19 at 24.

⁵⁶ According to Neethling, truthfulness is an element of the infringement of privacy, while falsity is an element of the infringement of identity; Neethling op cit note 19 at 24.

⁵⁷ McQuoid-Mason op cit note 5; Burchell op cit note 13 at 334; 395.

and regard placing a person in a 'false light' as a form of invasion of privacy. McQuoid-Mason⁵⁸, for instance, sees the core violation of placing a person in a false light in the 'unwanted publicity' it creates. In his opinion 'false light' cases thus need to be covered under privacy because, even though the information has been falsified, the actual invasion is the unwanted publicity.

2 HIV/AIDS AND PRIVACY

Although the protection of privacy is a core interest for HIV-infected individuals, as will be shown in this section, local literature on the subject remains scarce. So far only few scholars have discussed privacy in the light of HIV/AIDS and most of the few who have focus on a particular aspect of privacy.⁵⁹ Case law on the matter is also limited.⁶⁰

(a) *Protection of HIV status under the right to privacy*

Most people would consider their HIV status to be a private affair, because due to the way of transmission and the lack of a cure, HIV is a condition related to sex, death and disease — topics that allude to the most existential aspects of life and are therefore perceived as highly intimate. That a person's HIV status is a private fact was confirmed in *NM and Others v Smith and Others* where Madala J acknowledged that an individual's HIV status 'deserves protection against indiscriminate disclosure due to the nature and negative social context the disease has as well as the potential intolerance and discrimination that results from its disclosure'.⁶¹ He also emphasised the importance of the protection of privacy to 'encourage individuals to seek treatment and divulge information encouraging disclosure of HIV' and to initiate 'improvement of public health policies on HIV/AIDS'.⁶²

⁵⁸ McQuoid-Mason op cit note 5 at 231.

⁵⁹ Neethling op cit note 26 focuses on the recent judgment *NM and Others v Smith* and the liability of media defendants. See also: Ngweni op cit note 12; Simeon Maile 'Legal Aspects of the disclosure of HIV serostatus by educators' (2003) 23 (1) *South African Journal of Education* 78). Other publications focus solely on confidentiality: Mark Heywood 'Confidentiality or bust' (1998) *AIDS Legal Quarterly* 11; Fatima Hassan 'Confidentiality: tool of the trade' (1998) *AIDS Legal Quarterly*; Taitz op cit note 40.

⁶⁰ Neethling contention that 'in the recent past the courts have often been confronted with the protection of a person's right to privacy in connection with his or her HIV/AIDS status' (emphasis added) seems doubtful. The adjudication of four cases — three of which will be mentioned here — on a person's right to privacy in the context of HIV/AIDS over a period of 15 years suggests that case law is rather limited. See Neethling op cit note 19 at 37.

⁶¹ *NM and Others v Smith* supra note 1 para 42.

⁶² Ibid.

(b) *Violations of privacy in the context of HIV/AIDS*

Neethling⁶³ categorises invasions of privacy into two types: a person intrudes into the private sphere of another;⁶⁴ or a person discloses or reveals another's personal facts.⁶⁵ These types of infringements also apply in the context of HIV/AIDS.

(1) *Unauthorised blood tests*

The first type of infringement takes place where insurance companies, employers or others perform an HIV test on a blood sample without the informed consent of the person whose blood is tested.⁶⁶ The case of an unauthorised blood test for HIV was dealt with in *C v Minister of Correctional Services*⁶⁷ where the High Court found that such a test violated the prisoner's right to privacy.⁶⁸

(2) *Non-consensual HIV disclosure*

There are two examples of the second type of infringement. *Jansen van Vuuren and Another NNO v Kruger*,⁶⁹ the earliest jurisprudential paradigm, dealt with a non-consensual disclosure of a patient's HIV status. The case presented itself as a promising start for developing the common law on privacy and HIV/AIDS.⁷⁰ Recently, the Constitutional Court made its first

⁶³ Neethling op cit note 19 at 21.

⁶⁴ That is where an outsider comes into contact with a person or obtains information about his personal affairs.

⁶⁵ That is where one party exposes an individual or personal affairs of an individual to a third party against the will of the former.

⁶⁶ Aids Law Project 'HIV/AIDS — Current Law and Policy: Privacy and confidentiality' (2004) at 9; 11; 12; Ngwena op cit note 12 at 533.

⁶⁷ *C v Minister of Correctional Services* 1997 JOL 407 (T).

⁶⁸ The case dealt with a delictual action for damages based on a non-consensual HIV test. The Department of Correctional Services had taken a blood sample from an inmate which was, at a later point, subjected to an HIV test without the plaintiff's informed consent. The court stipulated that testing for HIV in prisons must be undertaken in accordance with the relevant Correctional Services Protocol which — rightly — required informed consent for an HIV test. Testing the plaintiff without informed consent thus violated his common law right to privacy and led to the granting of damages. See specifically *C v Minister of Correctional Services* supra at 431; 438; 441.

⁶⁹ *Jansen van Vuuren and Another NNO v Kruger* supra note 38.

⁷⁰ In this delictual case the plaintiff's doctor disclosed the plaintiff's HIV status without authorisation to two of his friends. The Supreme Court ruled in favour of the plaintiff, holding that the defendant had breached the plaintiff's right to confidentiality by disclosing his HIV status without authorisation. The Court ordered the defendant to pay damages of R5 000. The Supreme Court made it clear that enforcing medical confidentiality was vital for the protection of patient's privacy. The Supreme Court took a progressive approach by expressly endorsing the findings of the English case *X v Y & others* (1988 2 All ER 648 (QB)) that 'in the long run, preservation of confidentiality is the only way of securing public health' because if people fear breaches of confidentiality, patients will in future not come forward. Unless infected persons come forward, they cannot be counselled and treated and will infect other

ruling on an HIV disclosure and its implications in *NM and Others v Smith*.⁷¹ The court heard the case of three women whose HIV status was revealed in a book without authorisation. The court's decision has been thoroughly discussed by Neethling⁷² and Scott.⁷³

(3) *Imputation of HIV infection — a violation of privacy?*

A potential example of an infringement of privacy that magistrates often have to deal with is where one person publicly accuses someone of being infected with HIV or having AIDS, although such person is not infected with the virus.⁷⁴ It is doubtful whether this kind of behaviour would amount to an infringement of privacy.

As noted earlier, McQuoid-Mason's understanding of a violation of privacy includes placing a person in a false light, in cases where the law of defamation does not cover the conduct.⁷⁵ Thus, publicly imputing that a person is infected with HIV/AIDS would constitute an invasion of privacy. However, according to Neethling⁷⁶ an infringement of privacy is only possible where true personal facts are used in a manner exclusive to the individual. Therefore, the described false imputation would not constitute an invasion of privacy. It is submitted that an accusation in relation to HIV would not constitute defamation.⁷⁷ McQuoid-Mason's view that although the facts are untrue, the conduct exposes the person to unwanted publicity is

individuals. Furthermore, Joubert JA acknowledged the severity of consequences of non-consensual HIV disclosure by recognising that the '[d]isclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others, which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full blown AIDS'. See *Jansen van Vuuren and Another NNO v Kruger* supra at 854I–J.

⁷¹ *NM and Others v Smith* supra note 1.

⁷² Neethling op cit note 26.

⁷³ Helen Scott 'Liability for the Mass Publication of Private Information in South African Law: *NM v Smith* (Freedom of Expression Institute as Amicus Curiae)' 2007 18 *Stellenbosch Law Review* 387.

⁷⁴ The author facilitated discussions around HIV/AIDS and privacy and HIV/AIDS and crimen iniuria between magistrates at workshops in various South African provinces. A very high number of magistrates had heard cases where one person had accused another person of being infected with HIV or having AIDS.

⁷⁵ See the discussion on 'false light' cases under II.1.d.

⁷⁶ See references in note 54.

⁷⁷ This question will be discussed in more detail in a forthcoming article by the same author. In short: For defamation to be wrongful a 'reasonable person of ordinary intelligence and development' must consider the conduct to have tendency to undermine, subvert or impair a person's good name or reputation. Due to the objective nature of the civil defamation test, it is the values of the constitutional Bill of Rights that need to be considered when establishing what a reasonable or right-thinking person would regard as defamatory. Given that a reasonable person, ie a person with appropriate constitutional values, would not look down on someone because of the statement, it cannot be regarded as defamatory, even if it is a view held by the majority of South Africans. The line of argument is based on Kok, who has made the same argument when testing whether an imputation of homosexuality is

weak, because what is unwanted is the publication of these particular facts that are *false*, not the publicity. Neethling's approach to require truthfulness appears more appropriate. False facts cannot be regarded as part of the person or of his personal affairs. Though it may be difficult, the protection of an individual's 'true image' ought to be ensured through other legal tools such as the right to identity,⁷⁸ defamation⁷⁹ or *crimen iniuria*. If none of the existing legal remedies is applicable then the conduct is lawful. This result may seem unsatisfactory, because a person who is accused of having AIDS can surely feel violated and the imputation may lead to negative consequences such as discrimination or harassment. Legal remedies may be available for such negative consequences though.⁸⁰

(4) *Effects of infringements*

Currie and De Waal's⁸¹ assumption that privacy is protected for the realisation of other values is particularly true in the context of HIV/AIDS. A non-consensual HIV disclosure may put the HIV-infected individual at risk for further human rights violations. Fombad⁸² highlights that an unauthorised HIV disclosure may lead to rejection, ostracism and discrimination. Barrett-Grant et al⁸³ confirm that people with HIV/AIDS are refused employment, membership in employee benefit schemes, life insurance, bonds, proper health care and equal membership of medical aid schemes. Research shows that people living with HIV/AIDS generally, and women in particular, are also at risk for violence, sexual abuse and abandonment after HIV disclosure.⁸⁴ HIV disclosure puts women at risk for loss of economic support, blame, abandonment, physical and emotional abuse, discrimination

defamatory. See Anton Kok 'Homosexuality, The Bill of Rights and the Unlawfulness Criterion in the Law of Delict' (2001) 118 *South African Law Journal* 102 at 106.

⁷⁸ The problem with this approach is, however, that the right to identity may not be constitutionally protected, unless it is regarded as part of the right to dignity; McQuoid-Mason op cit note 5 at 231. The Constitutional Court acknowledged in *National Coalition for Gay and Lesbian Equality v Minister of Justice* that the right to dignity includes an individual's identity, stating that 'the violation of dignity under section 10 [. . .] offers protection to persons in their multiple identities and capacities', *National Coalition for Gay and Lesbian Equality v Minister of Justice* (CCT 11/98) para 120 available at <http://www.saflii.org/za/cases/ZACC/1998/15.html> (last accessed 27 October 2008).

⁷⁹ The law on defamation is also not inapplicable, see note 78 above.

⁸⁰ The problem itself is not a legal one. What needs to be addressed are the stigma around the disease and society's negative attitudes towards HIV-infected individuals.

⁸¹ Currie/De Waal op cit note 7 § 14 at 320.

⁸² Charles Manga Fombad 'The crisis of confidentiality in the control of the HIV/AIDS pandemic in Botswana' (2001) 43 *International Social Science Journal* 649; Fombad furthermore claims that 'no disease in history has had the stigma attached to it that HIV/AIDS has had'; Ibid at 644.

⁸³ Kitty Barrett-Grant/Derrick Fine/Mark Heywood/Ann Strode *HIV/AIDS and the Law — A resource manual* 2 ed (2001) § 2.4.4 at 38.

⁸⁴ L Vetten/K Bhana *Violence, Vengeance and Gender — A preliminary investigation into the links between violence against women and HIV/AIDS in South Africa* (2001) at 11;

and disruption of family relationships.⁸⁵ The protection of privacy is therefore crucial for the fulfilment of other rights such as physical and psychological integrity⁸⁶ and equality.⁸⁷ While negative effects may also occur where a person discloses his HIV status voluntarily, the latter might be more prepared for negative consequences and might know how to react to threats of violence and discrimination.

(c) *Adequate protection?*

Notwithstanding the recognition of privacy under South African law, it remains doubtful whether the right adequately protects HIV-positive people. Some scholars⁸⁸ argue that whilst the right can serve as an important deterrent, it is otherwise of limited utility because the adjudication necessarily renders public what the person wishes to keep private. According to Ngwena,⁸⁹ '[l]itigation is a disincentive as it brings the matter into the public arena, and thus paradoxically assuring an even wider dissemination of the very information that the plaintiff is seeking to protect'. Given that in the majority of cases the plaintiff will enforce the right only *after* it has been invaded, the right merely offers remedies for an *irrevocable violation*.

This criticism can partially be contested. Firstly, the court can apply 'protective measures' like hearing the case in camera and/or ordering that the plaintiff's name not be published. However, in the light of HIV specifically, tedious lawsuits remain problematic. Where the disease has progressed to AIDS, time may be crucial for an HIV-infected plaintiff because the disease is fatal. Of further concern are the expenses of an ongoing trial. Medical care for HIV is costly and the plaintiff might not have sufficient means for both litigation and medication.⁹⁰ These limitations may however be overcome once broader access to antiretroviral treatment is available, which will keep HIV-infected people healthy for longer and might increase their willingness and ability to claim their rights before the courts. Furthermore, it should be acknowledged that the right sets non-negotiable standards for the actions of government as well as private persons.

Secondly, the common law provides an interdict to restrain an invasion of privacy as an alternative to a time consuming trial.⁹¹ An interdict requires that the respondent has commenced or is threatening to commit an unlawful

Women are more vulnerable to violence due to gender inequalities and due to their low status in society.

⁸⁵ This will be discussed in more detail below under III.2.c.

⁸⁶ Bodily integrity is protected under both the common law and the constitutional law. See Neethling et al op cit note 8 § 10 at 321 and s 12(2) of the Constitution.

⁸⁷ The right to equality is protected under s 9 of the Constitution.

⁸⁸ Ngwena op cit note 41 at 535; 537; Matthew Weait 'Harm, Consent and the Limits of Privacy' (2005) 13 *Feminist Legal Studies* 98.

⁸⁹ Ngwena op cit note 41 at 535.

⁹⁰ Ibid at 535.

⁹¹ McQuoid-Mason op cit note 5 at 235.

act and that this act cannot be prevented in any other way.⁹² Therefore, if the court is satisfied that the applicant has a reasonable apprehension that his privacy will be irreparably injured and that there is no other remedy available, it will grant an interdict. This remedy is only feasible though where the applicant knew that the violation of privacy was imminent or where the right has already been invaded, which implies the irrevocable injury mentioned earlier.

III PART II: PUBLIC HEALTH INTERVENTIONS & THE LIMITATIONS OF PRIVACY

Privacy, like any other right, is not absolute. The right may be limited where it interferes with the rights of other individuals or the public, or the interests of the state. In the context of HIV/AIDS, privacy is particularly problematic in sexual relationships because an HIV disclosure may be crucial for the protection of uninfected sexual partners. Ideally, an HIV-infected individual would disclose his or her HIV status before engaging in risky sexual behaviour.⁹³ But what if an HIV-infected individual refuses to disclose his HIV status to his partner? Does the HCP who diagnosed the disease then have a duty to warn the partner? In answering this question the article will discuss public health interventions such as making HIV a notifiable disease and partner notification schemes, their implications on the right to privacy and their potential risks and benefits.

In addition to consensual sexual relationships, this section will scrutinise the justifiability of public health measures in the area of non-consensual sexual relations, specifically sexual offences. The newly enacted provisions on compulsory HIV testing of alleged sexual offenders seriously limit the right to privacy. But do they do so for the benefit of the victim?

⁹² Neethling et al op cit note 8 § 7 at 236.

⁹³ Every person is under a moral duty not to expose others to harm. However, at present South African law does not recognise a legal duty to disclose an HIV infection to a sexual partner. There is neither an HIV-specific statute nor a common law offence dealing with HIV disclosure or exposure per se. Yet, there is an 'indirect' legal duty, because an HIV-positive person could face criminal charges for exposing someone to HIV or for transmitting the disease. Possible criminal charges under the common law include (attempted) murder, homicide, and assault. Given that a number of prosecutorial difficulties arise (eg to provide evidence on the knowledge and intention to transmit the virus; causation), it may be very difficult to secure a conviction for these common law crimes though. During the recent law reform process regarding the Criminal Law (Sexual Offences and Related Matters) Amendment Act, the criminalisation of non-disclosure of HIV/AIDS was discussed, but the proposed provisions were not included in the Act. See Sarai Chisala 'Rape and HIV/AIDS: Who's Protecting Whom?' § 3 at 52–70 in L Artz/D Smythe (eds) *Should We Consent? Rape Law Reform in South Africa* (2008).

1 PRIVACY & NOTIFIABILITY

One public health intervention that was particularly sought in the United States (U.S.)⁹⁴ but also discussed in South Africa was to make either HIV, or AIDS, or both notifiable diseases. Where a disease has been declared 'notifiable', HCPs diagnosing the disease must inform the local health authorities. The purpose of creating categories of notifiable diseases can be active or passive disease control. Active disease control serves to locate and contact infected individuals and possibly submit them to coercive measures (for instance isolation).⁹⁵ The rationale of passive disease control is to enable accurate surveillance of the spread of a disease.⁹⁶ Although AIDS was listed as a communicable disease in terms of the 1987 'Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions' its mandatory reporting was never enforced.⁹⁷ Subsequent policies relating to notifiable medical conditions did not include AIDS.⁹⁸ Despite government's (renewed) intention to make AIDS a notifiable disease in 1999, this plan was not put into practice.⁹⁹ At the Health Summit in 2001, public health experts concurred that HIV and AIDS should not be made notifiable diseases because 'the stigma was too high'.¹⁰⁰

The decision to keep HIV and AIDS off the list of notifiable diseases is commendable because compulsory case reporting of HIV/AIDS is not an effective public health measure. Making HIV or AIDS a notifiable condition

⁹⁴ In the U.S. all states have legislation requiring health care professionals to report cases of AIDS to state health departments. Centres for Disease Control and Prevention 'Current Trends Update: Public Health Surveillance for HIV Infection — United States, 1989 and 1990' (1990) 39 *Morbidity and Mortality Weekly Report* 853 at 859–861 available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001846.htm> (last accessed 22 September 2008).

⁹⁵ SALRC *Aspects of the Law Relating to Aids – Working Paper* 85 (1995) at 149.

⁹⁶ *Ibid.*

⁹⁷ *Ibid* at 151; Edwin Cameron / Edward Swanson 'Public Health and Human Rights — The AIDS Crisis in South Africa' (1992) 8 *South African Journal on Human Rights* 200 at 217.

⁹⁸ See Government Notice No. R.328 of February 1991 'Declaration of Medical Conditions to be Notifiable Medical Conditions in Terms of the Health Act, 1977 (Act 63 of 1977)'. Notice No. R.328 was declared under the National Health Act 63 of 1977 which has, in its entirety, been replaced by the NHA. The author was unable to find any new Regulations on notifiable medical conditions. It is however clear from other documents by the Department of Health that AIDS has not been reintroduced to the list of notifiable diseases. See, for instance, the Department's latest reports on the prevalence of notifiable diseases, available at <http://www.doh.gov.za/facts/notify/index.html> (last accessed 19 September 2008).

⁹⁹ Adele Baleta 'Zuma defends decision to make AIDS a notifiable disease' (1999) 353 *The Lancet* 1599.

¹⁰⁰ Nono Simelela 'HIV/AIDS and TB: The dual epidemic and its challenges' Discussion Paper by the Department of Health, Health Summit 2001, available at <http://www.doh.gov.za/docs/misc/Departmentsummit01/section2c.pdf> (last accessed 19 September 2008).

is unnecessary for passive disease control. As Cameron and Swanson¹⁰¹ rightly point out, '[a]nonymous testing of blood samples collected for other purposes and unlinked from any personal information identifying the source of the blood' are just as useful for surveillance purposes as data obtained through compulsory case reporting, without the effect of infringing on privacy. In recent years, a number of HIV/AIDS prevalence and incidence studies have been successfully undertaken without HIV/AIDS being a notifiable disease.¹⁰²

With regard to active disease control, it needs to be emphasised that HIV/AIDS differs from other communicable diseases in that it is not transmissible through casual contact between infected and uninfected individuals. Furthermore, it remains unclear how making HIV/AIDS a notifiable disease per se could have a positive impact on public health. Surely, notifiability would have to be combined with other public health measures like partner notification to prevent the further spread of the disease. The potential benefits and drawbacks of partner notification will now be discussed.

2 PRIVACY & PARTNER NOTIFICATION

Governments from all over the world have raised the issue of whether the principles of confidentiality and informed consent hindered efforts to prevent the spread of HIV.¹⁰³ Particular concern has been expressed regarding the vulnerability of women to infection if their partners did not know their status, refused to disclose it or objected to practising safer sex.¹⁰⁴ One way of preventing the transmission of HIV to sexual partners was thought to be partner notification.¹⁰⁵ This is a process of identifying and contacting the sexual partner(s) of an individual who has a sexually transmitted infection and informing them that they have been exposed to HIV infection. The notification can be undertaken by the patient who was tested for HIV (source patient/client) himself, by the HCP or through their

¹⁰¹ Cameron/Swanson op cit note 97 at 228.

¹⁰² Rob Dorrington/Leigh Johnson/Debbie Bradshaw/Timothy-John Daniel (2006) *The Demographic Impact of HIV/AIDS in South Africa: National and Provincial Indicators for 2006*; O Shisana/T Rehle/L Simbayi/W Parker/K Zuma/A Bhana/C Connolly/Jooste S/V Pillay (eds) (2005) *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*; UNAIDS/WHO (2006) *Epidemic Update: December 2006* available at http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf (last accessed 9 October 2007).

¹⁰³ Susan Timberlake (UNAIDS) *'Opening up the HIV/AIDS epidemic — Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting'* (2000) at 5.

¹⁰⁴ Ibid.

¹⁰⁵ UNAIDS suggested the use of the term 'partner counselling', because 'partner notification' may be associated with coercion and pressure. See Timberlake op cit note 103 at 18.

combined efforts.¹⁰⁶ The following section focuses on the notification of the sexual partner by an HCP.¹⁰⁷

(a) *Comparative approaches to partner notification*

UNAIDS and the Canadian Advisory Committee on AIDS make similar recommendations regarding partner notification.¹⁰⁸ Emphasising the need for respect for the human rights of the source client and his partner, both organisations require that the source client be thoroughly counselled as to the need for partner notification in order to obtain his consent.¹⁰⁹ Only in limited circumstances should a notification be considered without the source patient's consent. This is where the source client (1) fails to apply appropriate behavioural changes, ie to practise safer sex; and (2) his partner is clearly identifiable; and (3) at real risk of HIV transmission, or has little reason to suspect that he is at risk.¹¹⁰ In the case of a non-consensual partner notification, the source client must be given advance notice of the HCP's intention to notify the partner.¹¹¹ The identity of the source client should not be disclosed during the notification.¹¹² UNAIDS acknowledges that this may not be feasible in practice, because in monogamous relationships the

¹⁰⁶ Timberlake op cit note 103 at 32.

¹⁰⁷ The terms 'patient', 'source patient/client' and 'partner' will be used in the 'masculine' form but should be read as referring to both males and females unless stated otherwise.

¹⁰⁸ Timberlake op cit note 103; Canadian Federal/Provincial/Territorial Advisory Committee on AIDS (1997) *Guidelines for Practice for Partner Notification in HIV/AIDS*. The Canadian guidelines were developed to provide a framework that provinces and territories in Canada can use to shape their partner notification programmes. Ralf Jurgens HIV testing and Confidentiality: Final Report (2001) at 364 available at <http://library.catie.ca/PDF/P42/16067.pdf> (last accessed 27 October 2008). More recently, a different Canadian working group has revisited the issue of partner notification and made recommendations for a legal framework for consideration by the provinces and territories. See Ronda Bessner 'Persons who fail to disclose their HIV/AIDS status: Conclusions reached by an Expert Working Group' (2005) 31 *Canada Communicable Disease Report* 53. However, the working group's suggestions have not replaced the Advisory Committee's guidelines.

¹⁰⁹ Timberlake op cit note 103 at 22; Canadian Federal/Provincial/Territorial Advisory Committee on AIDS *Guidelines for Practice for Partner Notification in HIV/AIDS* at 6–7 as quoted by Jurgens op cit note 108 at 364–365.

¹¹⁰ Timberlake op cit note 103 at 22; Canadian Federal/Provincial/Territorial Advisory Committee on AIDS at 6–7 as quoted by Jurgens op cit note 108.

¹¹¹ Timberlake op cit note 103 at 22.

¹¹² Timberlake op cit note 103 at 22; The Canadian guidelines are very detailed when it comes to the importance of protecting the identity of the source client. They set out that (1) disclosure of the names of the partner(s) must be voluntary, non-coercive and non-prejudicial; (2) strict confidentiality of all information concerning both the source client (including his identity) and the partner(s) be maintained; and (3) when partners are told of the possibility of HIV exposure, no additional information be given which may identify the source patient. Canadian Federal/Provincial/Territorial Advisory Committee on AIDS *Guidelines for Practice for Partner Notification in HIV/AIDS* at 6–7 as quoted by Jurgens op cit note 108 at 364–365.

notified partner will know who put them at risk.¹¹³ The Canadian and UNAIDS guidelines furthermore envision that it should be ensured that 'social and legal support for the source client and other relevant parties' are available because, according to UNAIDS, these may be necessary 'to protect them from any physical abuse, discrimination and stigma which may result from partner counselling'.¹¹⁴

It is laudable that UNAIDS and the Canadian Advisory Committee attempt to protect privacy where possible. Furthermore, the precautions that need to be taken before a non-consensual notification prevent HCPs from regarding notification as 'standard practice'. However, the UNAIDS and Canadian principles are based on an idealistic setting (eg the availability of social and legal support; the HCP's ability to counsel the source client repeatedly) that regularly does not exist in resource-poor settings. In addition, UNAIDS' contention that only few properly counselled patients would refuse to disclose their status¹¹⁵ is doubtful and will depend on sociological factors such as the overall levels of acceptance of HIV-infected people and stigma as well as personal factors like the prevalence of inter-personal violence in the source patient's relationship.¹¹⁶

The American Medical Association developed a policy on 'HIV/AIDS Reporting, Confidentiality, and Notification', which includes comparable, but less detailed provisions on partner notification.¹¹⁷ The Association strongly recommends that states adopt contact-tracing and partner notification systems to provide clear guidelines for public health authorities and physicians. The guidelines request that the HCP try to persuade the source patient to 'cease all activities that endanger unsuspecting others and inform those whom he [. . .] might have infected'.¹¹⁸ Where this attempt fails, notification that protects 'to the greatest extent possible' the confidentiality of the source patient should follow.¹¹⁹

Interestingly, the Canadian and American guidelines by professional bodies are not necessarily reflected in legislation. Jurgens'¹²⁰ research shows

¹¹³ Timberlake op cit note 103 at 22.

¹¹⁴ Timberlake op cit note 103 at 7; Canadian Federal/Provincial/Territorial Advisory Committee on AIDS *Guidelines for Practice for Partner Notification in HIV/AIDS* at 6–7 as quoted by Jurgens op cit note 108 at 364–365. According to the Canadian guidelines, the notification must also be delivered in a language and form that is understandable and culturally sensitive. Ibid.

¹¹⁵ Timberlake op cit note 103 at 7.

¹¹⁶ This will be addressed in more detail below.

¹¹⁷ American Medical Association *HIV/AIDS Reporting, Confidentiality, and Notification* (n.d.).

¹¹⁸ Ibid at H-20.915 (3).

¹¹⁹ According to the policy standards, this must also include the physician's right to exercise ethical and clinical judgement. Ibid.

¹²⁰ In Canada, some provinces *require* partner notification, while other states *allow* partner notification, and in other parts of the country legislation concerning partner notification is non-existent. The situation in the U.S. is similar. At least 33 American states have enacted HIV/AIDS-specific partner notification laws varying from obli-

that legislation on partner notification in Canada and the U.S. differs substantially from state to state. But then again, legislation and practice may also be inconsistent.¹²¹ A few U.S. programmes take the risk of intimate partner violence after notification into account. Timberlake¹²² points out that New York, for instance, although known for its rigid notification scheme, implemented domestic violence screening into their partner notification system. In California notification is deferred indefinitely where a violent reaction by the partner is expected.¹²³

(b) *The South African approach*

(1) *Partner notification in South Africa*

Unwillingness of a patient to disclose his HIV status and to use condoms clearly puts his partner at risk for infection. Whereas North American countries aim to protect the sexual partner through notification programmes, such programmes do not exist in South Africa. However, the HPCSA and the South African Medical Association¹²⁴ (hereafter: SAMA) both developed guidelines that provide advice for HCPs on how to act in situations where the patient refuses to disclose his status and to practise safer sex.¹²⁵

The HPCSA's guidelines emphasise that any decision on the disclosure of the HIV status must generally be made in consultation with the patient, but '[i]f the patient's consent cannot be obtained, ethical guidelines recommend that the HCP should use his discretion whether or not to divulge the information to other parties involved who are at clear risk or danger'.¹²⁶

Under the HPCSA's policy the HCP must follow a certain procedure before informing the sexual partner(s). First, the HCP has to counsel the patient on the importance of disclosing the HIV status to his sexual partner(s) and of applying appropriate behavioural changes to prevent HIV transmission. The HCP must then offer to support the patient during the disclosure. Where the patient still refuses to disclose and to take other measures to prevent HIV transmission, the HCP may disclose the HIV status to the partner(s) after having advised the patient that it is his ethical obligation to do so and having requested his consent. Interestingly, the guidelines also require

gations to authorisations for notifications. According to Jurgens, most provinces in Canada, for instance, have adopted largely informal contact tracing procedures, often with a focus on voluntary contact tracing. Jurgens op cit note 108 at 368–371.

¹²¹ Ibid.

¹²² Timberlake op cit note 103 at 33.

¹²³ Timberlake op cit note 103 at 34.

¹²⁴ The SAMA is a professional organisation for public and private sector medical practitioners.

¹²⁵ HPCSA op cit note 45; SAMA *Ethical and Human Rights Guidelines on HIV and AIDS Part A — General Principles* (2006).

¹²⁶ HPCSA op cit note 45 at 10.3.

the counselling to draw attention to the possibility of ‘violence and other adverse consequences’ of the disclosure.¹²⁷

The SAMA guidelines on HIV disclosure are slightly stricter than those of the HPCSA. They stipulate that confidentiality may only be breached if the partner(s) of the patient can be *clearly* identified, if there is a *real* risk that the partner(s) will become infected and if there is *no other way* to protect the partner.¹²⁸ A new development since the revision of the SAMA guidelines is that where a patient strongly believes that the disclosure of his HIV status entails a risk of harm, the HCP’s primary duty is to protect the life of the patient; the HIV status should not be disclosed in these circumstances.¹²⁹ This recommendation makes it clear that the primary duty of the HCP is towards his patient and not their partner(s).

(2) *An analysis of the South African guidelines*

The HPCSA and SAMA policies lack sufficient practical guidance for HCPs who are confronted with the decision of whether or not to notify a sexual partner, and fail to address important legal questions relating to the limitation of privacy.

(a) Practical concerns

The main concern regarding the HPCSA’s policy is that it allows HCPs discretion on whether or not to inform the sexual partner of the source patient, and instead of guiding this decision, the policy simply states that HCPs have to accept ‘full responsibility’ for their decision.¹³⁰ Although the steps that need to be taken *before* the disclosure are clearly spelled out (counselling, offer of support etc.), the guidelines remain silent on important aspects like what factors should influence the decision of notifying the partner. The SAMA policy provides slightly more detail on when a partner should be notified.¹³¹

Furthermore, both policies lack provisions on how the HCP should proceed with the disclosure. Questions relating to urgency and how the notification should be undertaken (in person? in writing? via the phone?) are left unanswered. Although the HPCSA guidelines mention ‘the possibility of violence and other adverse consequences’ as a result of the disclosure, they fail to offer any recommendations on how to prevent or deal with such consequences. The SAMA policy suggests that a partner should not be notified where the patient is at risk of harm.

Another problematic aspect is that under the South African as well as the comparative policies, a notification of the partner is envisioned where the source patient refuses to disclose his HIV status and to practise safer sex and

¹²⁷ Ibid at 10.3.5.

¹²⁸ SAMA op cit note 128 at 5.6.

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ See above under III.2.b.(1).

where the partner is at real risk. The question is: How does the HCP know whether this is the case? Is a 'promise' by the source patient sufficient to put the notification off? The SAMA guidelines stipulate that the HCP must have 'reason to believe that the patient is posing a risk to the sexual partner' and that the HCP may be required to show that he was acting 'on substantial information and not mere suspicion'. This highlights that a notification requires a thorough risk assessment by the HCP. In practice, however, the HCP relies on what his patient tells him.¹³²

An important difference between the South African protocols and the comparative guidelines from Canada is that the former envision disclosing *the HIV status of the source patient* instead of warning the partner of the risk of having been exposed to HIV. Where the HIV status of the source patient is disclosed, there is an automatic breach of privacy. Preferably, the HCP should use an anonymous warning relating to HIV exposure. Although an anonymous notification does not necessarily prevent a breach of confidentiality — because the source patient might be the only sexual partner of the notified individual — there is at least no *automatic* breach of privacy.¹³³

(b) Legal concerns

The HPCSA and SAMA guidelines state that to date there is no legal clarity on whether the notification of a sexual partner by an HCP is an 'acceptable limitation of the right to privacy'.¹³⁴ One important issue is thus: Could a patient sue an HCP for disclosing his HIV status to his partner? Another crucial question that is overlooked in the guidelines is: Could a partner of an HIV-positive individual sue the HCP for not warning him or her about the risk of exposure to HIV? In other words, does the HCP have a duty to warn the patient's partner? Although these questions must be clearly distinguished, they may in certain circumstances be intertwined. If it is established that the HCP *does* have a legal duty to inform the patient's partner, such notification must then be a justifiable limitation of privacy. If, on the other hand, the HCP is under *no* legal duty to warn the partner, this would not necessarily imply that a notification constitutes an unjustifiable limitation of privacy.

(i) Limitation's of a patient's privacy

An HIV disclosure by the HCP without the patient's consent could violate the constitutional and the common law right to privacy as well as s 14(1) NHA. But privacy is not absolute; it finds its limits where it clashes with other people's rights. Both the common law and the constitutional law

¹³² The HCP could only resort to contacting the sexual partner and ask him about the disclosure but this already implies an HIV disclosure.

¹³³ Health care professionals also need to keep in mind that the cooperation of the patient may be necessary to obtain information on the name and/or contact details of the sexual partner(s).

¹³⁴ HPCSA op cit note 45 at 10.3. The SAMA guidelines state that 'in the absence of case law in this regard, no guarantees can be provided on how the courts and/or the HPCSA will view such disclosures'. SAMA op cit note 128 at 5.6.

require that conflicting interests be balanced.¹³⁵ In the case of HIV disclosure, the patient's right to privacy needs to be weighed against his partner's right to bodily integrity.¹³⁶ The potential consequences of a non-disclosure are far worse for the partner than the effects of a non-consensual disclosure for the source patient: the partner is at risk of getting infected with an incurable disease, whereas the patient's trust in the HCP is betrayed.¹³⁷ It is generally agreed that the interest in life outweighs the interest in privacy. It could therefore be argued that if there is a real risk for the partner (because the patient emphasises that he will not disclose his HIV status and will not use condoms) and no other way for the HCP to protect the partner, the doctor's breach¹³⁸ of confidentiality would be justified. As a result, an HCP may disclose his patient's HIV status — but only in certain circumstances that have to be tested on the merits of each case.

Although an HIV disclosure may constitute a justifiable limitation of privacy, it is suggested that the ambiguity of the guidelines be addressed in order to provide HCPs with guidance on when and how it is justifiable to undertake a notification of the patient's partner.

(ii) Legal duty to act

The fact that a notification by the HCP may be a justifiable limitation of privacy does not tell us whether the HCP is under a legal duty to actually undertake such notification. Under South African common law, the general rule is that a person does not act wrongfully where he 'fails to act positively to

¹³⁵ Under the common law, the balancing of interests is undertaken under the element of wrongfulness and is based on the *boni mores*. See Neethling et al op cit 8 § 3 at 34. In the case of the constitutional law, this test is done as the second stage of the analysis and is based on the limitation clause, which stipulates that the following factors need to be taken into account: the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and the purpose; and whether there are less restrictive means to achieve the purpose (s 36(1)(b), (c), (d), (e) of the Constitution). Also see note 10.

¹³⁶ Bodily integrity is protected under both the common law and the constitutional law. See references in note 86.

¹³⁷ Kenneth Kipnis 'A Defense of Unqualified Medical Confidentiality' (2006) 6 *American Journal of Bioethics* 7 at 13; Elaine Gibson 'Medical Confidentiality and Protection of Third Party Interests' (2006) 6 *American Journal of Bioethics* 23 at 23. Despite this agreement, Kipnis (ibid) advocates for unqualified medical confidentiality, whereas respondents to his article reject such a broad concept of confidentiality. See Gibson (ibid) at 126; John Blaint 'Should Confidentiality in Medicine Be Absolute?' (2006) 6 *American Journal of Bioethics* 19; James G. Hodge 'The Legal and Ethical Fiction of "Pure" Confidentiality' (2006) 6 *American Journal of Bioethics* 21.

¹³⁸ Gibson (ibid) holds that a disclosure against the patient's wishes cannot be qualified as a breach of confidentiality, but that this is merely an 'exception to the duty of confidentiality'. This understanding should be rejected because it limits the scope and applicability of confidentiality. It is preferable to define the concept widely and then test whether a violation is justifiable instead of limiting the scope of the right in the first place.

prevent harm to another'.¹³⁹ Courts can only depart from this rule in exceptional circumstances.¹⁴⁰ However, a person may be liable for an omission if he was under a legal duty to act.¹⁴¹ In *Van Eden v Minister of Safety and Security* the court held that a 'defendant is under a legal duty to act positively [. . .] if it is reasonable to expect of the defendant to have taken positive measures to prevent the harm'.¹⁴² According to the decision in *Minister of Law and Order v Kadir* 'such a duty arises [. . .] when the circumstances are such, not only that the omission evokes moral indignation, but that the legal convictions of the community demand that it be regarded as wrongful and that the loss should be compensated by the person who failed to act positively'.¹⁴³

Van der Walt/Midgley¹⁴⁴ compiled a list of factors that courts have taken into account when determining whether the defendant was under a duty to act:

the foreseeability and possible extent of harm; the degree of risk that the harm will materialise; the interests of the defendant and the community; who has control over the situation; the availability of practical preventative measures, and the chances of their success; whether the cost in preventing the harm is reasonably proportional to the harm, and whether or not other practical and effective remedies are available.

Furthermore, the following aspects might indicate the existence of a legal duty to act: prior (harmful) conduct; control of a dangerous object; and the existence of a special relationship or special knowledge.¹⁴⁵ Special relationships can be based on contractual relationships, on a person's occupation or office, or on the impression created by a party that he will protect the other party.¹⁴⁶

An HCP would thus have a legal duty to inform the patient's partner if the boni mores of the community demand that he does. The existence of a special relationship between the HCP and the patient's partner could indicate such a duty. It is generally accepted that a special relationship exists between the HCP and his patient. The Hippocratic Oath stipulates that HCPs must act in the best interest of *their patients*.¹⁴⁷ Unless the HCP is the couple's family physician and thus has a doctor-patient relationship with both the patient and his partner, there is no basis for assuming a special

¹³⁹ Neethling et al op cit note 8 § 3 at 51; 73; J C van der Walt/J R Midgley *Principles of Delict* (2005) at 84.

¹⁴⁰ Neethling et al op cit note 8 § 3 at 68.

¹⁴¹ Neethling et al op cit note 8 § 3 at 51.

¹⁴² *Van Eden v Minister of Safety and Security* 2003 (1) SA 389 (SCA).

¹⁴³ *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A).

¹⁴⁴ See Van der Walt/Midgley op cit note 139 at 85 for further references.

¹⁴⁵ Van der Walt/Midgley op cit note 139 at 85.

¹⁴⁶ Neethling et al op cit note 8 § 3 at 62–65.

¹⁴⁷ Ludwig Edelstein 'The Hippocratic Oath: Text, Translation and Interpretation' in Owsei Temkin/C Lilian Temkin *Ancient medicine: Selected Papers of Ludwig Edelstein* (1967) at 37.

relationship between the HCP and his patient's partner.¹⁴⁸ Most South Africans may not even have a family physician in the first place. When getting tested for HIV, most people will do so at public health facilities — where testing is free of charge — and not at a (private) doctor's practice. A special relationship between the HCP and the patient's partner is therefore unlikely to exist.

Contrary to this view, the Supreme Court of California found in *Tarasoff v Regents of the University of California* that a 'special relationship to either the person whose conduct needs to be controlled or [. . .] to the foreseeable victim of that conduct' (emphasis added) is sufficient.¹⁴⁹ Accordingly, the Court decided that the special relationship between the psychologist and his patient was sufficient to create a legal duty for the psychologist to warn the victim.¹⁵⁰ The Court took into account the fact that numerous decisions in other U.S. jurisdictions had accepted a doctor's duty to warn members of the patient's family of his or her contagious disease.¹⁵¹ In the absence of similar case law in South Africa and given the strict test for determining a legal duty to act (on a case-by-case basis), it is unlikely that our courts would concur with such a broad understanding of a special relationship.

Despite the lack of a special relationship, the HCP could be under a legal duty to warn the partner if the mores of the community require him to act because of his special knowledge. The HCP is the only person — apart from the patient — who knows about his infection with HIV. If the patient refuses to disclose his status to his partner, the only way to find out would be through the HCP. Furthermore, the harm to the patient's partner is

¹⁴⁸ Such a case was dealt with in the Australian decision *Harvey & Ors v PD* (2004) NSWCA 97, where it was held that the doctor breached his duty of care to the sexual partner, who was also his patient. In this case the plaintiff and her fiancé attended a joint consultation for HIV tests and sexually transmitted diseases at the respondents' medical practice. The first respondent, Dr Harvey, who saw the couple, knew that the plaintiff had a particular concern about her fiancé being infected with HIV. Whereas the plaintiff tested HIV negative, her fiancé tested HIV positive, but showed her a forged or fraudulently obtained HIV negative test result. Subsequently, the plaintiff acquired HIV from her fiancé. The New South Wales Court of Appeal upheld the trial court's finding that the doctors were liable for negligence. The Court ruled that, during the initial joint consultation, Dr Harvey should have addressed the fact that in the absence of consent he was legally prohibited from disclosing any information concerning the HIV status of one to the other, and hence, should have advised the plaintiff and her future husband to have a mutual disclosure of test results. Had Dr Harvey conducted the initial consultation more thoroughly, the plaintiff and her fiancé probably would have consented to receiving the test results together and thereby to sharing the test results with each other.

¹⁴⁹ *Tarasoff v Regents* (1976) 551 P.2d 334 at 343.

¹⁵⁰ *Ibid.*

¹⁵¹ *Tarasoff v Regents* *supra* note 149 at 344. *Wojcik v Aluminum Co. of America* (1959) 18 Misc.2d 740 (183 N.Y.S.2d 351, 357–358); *Davis v Rodman* (1921) 147 Ark. 385 (227 S.W. 612, 13 A.L.R. 1459); *Skilling v. Allen* (1919) 143 Minn. 323 (173 N.W. 663, 5 A.L.R. 922); *Jones v. Stanko* (1928) 118 Ohio St. 147 (6 Ohio L.Abs. 77, 160 N.E. 456).

foreseeable (where the patient informs the HCP that he is not going to disclose and practise safer sex).¹⁵² Last but not least, the extent of harm for the sexual partner is substantial, given that there is still no cure for HIV/AIDS.

Nevertheless, a legal duty to warn the sexual partner of an HIV-infected individual must be rejected. The persons who have control over the situation — another important factor in the balancing — are the patient and his or her sexual partner. Preventative measures are in their hands. Let us first look at the patient. It appears unreasonable to transfer a patient's responsibility to the HCP. First and foremost, it is the *patient's* responsibility to protect his partner from getting infected with a contagious diseases by practising safer sex and/or disclosing his status.¹⁵³ Shifting this responsibility onto the HCP and making him liable for damages would amount to punishing the HCP for the misconduct of his patients. It would be contrary to the legal convictions of the community to expect doctors to fulfil the duties of their patients and make them compensate for the losses.

One could also make the argument that in addition to the patient, it is within the partner's control to protect himself from HIV/AIDS. Crewe¹⁵⁴ noted that although South Africans are aware of HIV and how it is transmitted, this awareness has so far not resulted in personal behaviour change. In a country like South Africa, where 15,4% of adult males (15–49 years) and 21,2% of adult females (15–49 years) are HIV positive, nobody can truly think that he is not at risk for HIV infection.¹⁵⁵ HCPs should therefore not be held liable for people's failure to protect themselves. The argument that some people may not be in a position to protect themselves effectively, for instance because they are in an abusive relationship, does not detract from this argument. If a person is unable to negotiate safer sex, a notification by the HCP informing him of his risk for HIV will also be unlikely to help him.¹⁵⁶

Another important aspect is that a general legal duty for HCPs would seriously undermine patient confidentiality, which is not only a fundamental principle of any doctor-patient relationship, but also particularly important in the fight against HIV/AIDS. Only when people know that their health information will be protected will they come forward to get tested, particularly in the current climate of stigma.¹⁵⁷

¹⁵² Although the risk of HIV transmission is relatively low from a single sexual exposure, it is likely that a long-term or permanent partner will eventually become infected because of the repeated exposure.

¹⁵³ Whether it is sufficient to practise safer sex without disclosing the HIV status is another question that goes beyond the scope of this article.

¹⁵⁴ M Crewe 'South Africa: Touched by the vengeance of AIDS' (2000) 7 *South African Journal of International Affairs* 23 at 23; please note that there is a drafting glitch in this particular sentence of the article.

¹⁵⁵ Dorrington et al op cit note 102 at 8.

¹⁵⁶ This will be discussed in more detail under III.2.c.(2.).

¹⁵⁷ Although some American scholars insist that patients will come forward, get tested and seek treatment despite the threat of disclosure, it should be taken into

(c) *Partner notification — a gendered perspective*

Although partner notification is regarded as an important public health tool in other countries, it remains doubtful whether it should be introduced in South Africa.¹⁵⁸ As noted earlier, the aim of notification schemes is to protect the partner(s) of an HIV-infected person who are unaware of their risk, particularly women in heterosexual relationships.¹⁵⁹ Despite the aim of fighting gender inequalities, it will be argued here that partner notification programmes might fail just because of them. In addition, a number of practical challenges undermine the effectiveness of such programmes.

(1) *Notification of a male partner*

In South Africa, women would be disproportionately affected by a partner notification scheme. Firstly, more females than males are infected with HIV/AIDS,¹⁶⁰ and secondly, women are the ones who are predominantly tested for HIV through antenatal programmes.¹⁶¹ If an HCP notifies a male partner and the latter can identify the source patient — which will be the case in monogamous relationships — the woman may face numerous negative consequences. Both international and national research shows that HIV disclosure may put women at risk for loss of economic support, emotional abuse and blame, abandonment by partner and family, physical abuse including extreme violence or even death and discrimination.¹⁶²

account that the American setting is very different from the South African, where HIV is still highly stigmatised. Furthermore, Kipnis correctly points out that it is difficult to gather reliable data on whether people are seeking treatment despite the threat of disclosure or not. Gibson op cit 138 at 23; Kipnis op cit 138 at 14. Also see the discussion under III.2.c.(4).

¹⁵⁸ Sven Trelle/Aijing Shang/Linda Nartey/Jackie A Cassell/Nicola Low 'Improved effectiveness of partner notification for patients with sexually transmitted infections: systematic review' (2007) 334 *British Medical Journal* 354 at 354.

¹⁵⁹ Timberlake op cit note 103 at 5.

¹⁶⁰ The HIV/AIDS prevalence rate among females aged 15–49 is 21,2%; among males in that age group the infection rate is 15,4%. In certain age groups the disparity between male and female infection rates is a lot higher. For instance, among youths aged 15–24 years 3,7% of males, but 16,9% of females are infected; among the 25–29 year olds the infection rate for females is 32,5% whereas it is 'only' 21,8% for men. Dorrington et al op cit note 102 at 28; Women have a greater risk of contracting HIV due to the physiological features of the vagina, the high viral load of semen and the possibility of unnoticed infections of their genital organs.

¹⁶¹ Shanaaz Mathews 'Criminalising deliberate HIV transmission' (2006) 96 (4) *South African Medical Journal* 312 at 313.

¹⁶² See Suzanne Maman/Amy Medley (WHO) *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes* (2004) at 3; Karen H Rothenberg/Stephen J Paskey 'The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy and the Law' (1995) 85 (11) *American Journal of Public Health* 1569 at 1571; Suzanne Maman/Jacquelyn Campbell/Michael D Sweat/Andrea C Gielen 'The intersections of HIV and violence: directions for future research and interventions' (2000) 50 *Social Science and Medicine* 459 at 474; Claudia Watts/Charlotte Garcia-Moreno 'Violence against

Power imbalances between males and females, economic dependency and violence against women, particularly domestic violence, are widespread in South Africa.¹⁶³ An HIV disclosure through partner notification therefore has the potential to put a woman's livelihood at risk. If it were to be introduced in South Africa, it would need to entail comprehensive and effective screening mechanisms to assess and prevent adverse consequences of the notification.

(2) *Notification of a female partner*

Informing a woman that her male partner is HIV positive does in itself not put her in a position to negotiate safer sex. While some will be able to discuss the necessity of behaviour change with their partner, women living in unequal or abusive relationships may not be that fortunate. Due to power imbalances, many women are not in a position to make choices about their sexuality.¹⁶⁴ Accordingly, some women would know that they are at risk while being unable to protect themselves. The only positive outcome would then be that they could access voluntary counselling and testing (VCT) services for HIV and seek support.

(3) *Practical challenges*

Whether a notification can be undertaken will largely depend on the cooperation of the source patient. The HCP relies on his help for the name or contact details of the sexual partner as well as for the determination of risk of the partner. Notification schemes (as well as the South African guidelines for HCPs) only foresee a notification if the source patient is unwilling to disclose his status or fails to practise safer sex. There is however no indication of how an HCP is supposed to monitor the sexual behaviour of the source patient. An HCP could only notify the partner where the source client openly admits that he will not practise safer sex. In addition, the protection of the identity of the source patient will be impossible in monogamous relationships and may even be problematic when a casual contact is notified.

women: its importance for HIV/AIDS' (2000) 14 *AIDS* S253 at S259; Timberlake op cit note 103 at 3; Linda J Koenig/Jan Moore 'Women, Violence, and HIV: A Critical Evaluation with Implications for HIV Services' (2000) 4 *Maternal and Child Health Journal* 103 at 104; T A Sixgashe/R Baggaley/C Mathews *The Benefits and Harms of Disclosing HIV Status to Sexual Partners: Data from the Khayelitsha Mother to Child Transmission (MTCT) Pilot Project*, Paper presented at the 13th International AIDS Conference, Durban as quoted in Vetten/Bhana op cit note 84 at 11.

¹⁶³ For an overview of studies examining levels of domestic violence see L Vetten 'Violence against women: Good practices in combating and eliminating violence against women' (2005) Expert Paper for the UN Division of the Advancement of Women, available at <http://www.un.org/womenwatch/daw/egm/vaw-gp-2005/documents.html> (last accessed 2 February 2008).

¹⁶⁴ Vetten references several studies that highlight difficulties in relation to negotiating condom use, see Vetten/Bhana op cit note 84 at 10.

(4) *Implications of partner notification*

Another foreseeable challenge is that partner notifications may drive at-risk individuals away from VCT services for fear of breaches of confidentiality. People who fear HIV disclosure and the resulting discrimination may choose to rather not get tested at all.¹⁶⁵ In the current climate, it is likely that creating notification programmes will prevent people from getting tested, thereby counter-acting the public health goal of getting as many people tested as possible. Without people getting tested, the chain of transmission cannot be disrupted and available services such as antiretroviral medication would not be fully used.

(5) *Conclusion*

Partner notification requires substantial financial and human resources — resources that are scarce in South Africa. Instead of introducing costly notification schemes that only reach a very limited number of people — the sexual partners of HIV-infected individuals who got tested for HIV — public health interventions such as universal ‘know-your-status’¹⁶⁶ and safer sex campaigns advertised by mass communications, an increase of VCT sites as well as increasing the distribution of female condoms¹⁶⁷ will probably be more effective in the prevention of HIV/AIDS. Public health initiatives should also encourage couples to get tested and have their results disclosed to them together.¹⁶⁸ Rather than disclosing an individual’s status without consent, patients should be counselled on the benefits of HIV disclosure and should be offered assistance by the HCP when doing so.

(d) *Outlook*

While the lack of disclosure and behaviour change among people living with HIV/AIDS may be concerning, the bigger problem seems to be that many

¹⁶⁵ Mathews op cit note 161 at 312.

¹⁶⁶ Kevin M De Cock/Dorothy Mbori-Ngacha/Elizabeth Marum ‘Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century’ (2002) 360 *The Lancet* 67 at 70.

¹⁶⁷ Increasing the availability and acceptability of female condoms has so far been neglected in South African public health efforts. Whereas 346 million male condoms were distributed by 2004, distribution of female condoms only reached 0,2 million in 2003. Dorrington et al op cit note 102.

¹⁶⁸ Rhoda K Wanyenze/Cecilia Nawawu/Alice S Namale/Bernard Mayanja/Rebecca Bunnell/Betty Abang/Gideon Amanyire/Nelson K Sewankambo/Moses R Kamya ‘Acceptability of routine HIV counselling and testing, and HIV seroprevalence in Ugandan hospitals’ (2008) 86 *Bulletin of the World Health Organization* 302 at 306; De Cock et al op cit note 166 at 70. Couple counselling and testing could particularly benefit discordant couples, in that HIV infection of one partner might be considered as a ‘mutual’ problem and how to prevent infecting the HIV negative partner could be discussed with both partners.

people do not know their status in the first place.¹⁶⁹ In one of their investigations into 'Aspects of the Law Relating to AIDS', the SALRC said that —

since most persons in South Africa are unaware of their HIV status, harmful HIV-related behaviour cannot be said to be the major cause of the spread of the epidemic in our society. Harmful behaviour is thus the exception and not the rule and any steps taken to address such behaviour should take into account that these will be directed at limited and exceptional behaviour.¹⁷⁰

Intentional, harmful exposure to HIV by those who know their status is thus not the main problem. Twenty years into the epidemic, people are still rather reluctant to get tested for HIV. Many think they are not at risk; others simply prefer not to know their status. One method to scale up the rate of testing is to introduce routine testing for HIV. While HIV testing is usually required by the patient and is thus 'client-initiated', emphasis is now put on so called 'provider-initiated' HIV tests. Provider-initiated means that HCPs routinely offer such tests to all patients, irrespective of their presenting illness; the patient then has the option to refuse the test.¹⁷¹ UNAIDS/WHO recommend that a routine offer of testing be 'made to all patients seen in clinical and community based health service settings where HIV is prevalent and antiretroviral treatment is available [. . .] but who are asymptomatic'.¹⁷²

Botswana is one of the first African countries to have included routine HIV testing in their health care services.¹⁷³ Uganda has introduced free routine HIV testing at two large Ugandan hospitals and found that such testing was 'feasible and highly acceptable'.¹⁷⁴ Given that routine HIV testing requires the patient's informed consent, it does not violate the right to privacy in any way.¹⁷⁵

¹⁶⁹ F Viljoen 'Disclosing in an age of AIDS: Confidentiality and community in conflict?' in AIDS and Human Rights Research Unit, University of Pretoria (ed) *Righting Stigma: Exploring a rights-based approach to addressing stigma* (2005) 64 at 66.

¹⁷⁰ SALRC *Fifth Interim Report on Aspects of the Law Relating to AIDS — The Need for a Statutory Offence Aimed at Harmful HIV-Related Behaviour* (2001) at xiii.

¹⁷¹ UNAIDS/WHO (2004) 'UNAIDS/WHO Policy Statement on HIV Testing'; Wanyenze et al op cit note 168.

¹⁷² UNAIDS/WHO *ibid*.

¹⁷³ M A Tadesse *HIV Testing from an African Human Rights System Perspective: An Analysis of the Legal and Policy Framework of Botswana, Ethiopia and Uganda* at 37; Alexandra Zavis 'Botswana adopts new approach to HIV tests' Mail&Guardian Online (5 January 2006), available at <http://www.mg.co.za/article/2006-01-05-botswana-adopts-new-approach-to-hiv-tests> (last accessed 19 September 2008).

¹⁷⁴ Wanyenze et al op cit note 168 at 304.

¹⁷⁵ However, other aspects of routine testing may be problematic. As noted above, UNAIDS/WHO only recommend routine testing where patients have access to antiretrovirals. It seems unethical to encourage people to get tested and then not have any medication for the treatment of the condition. Another concern is that patients may be reluctant to question the suggestion of the doctor or HCP and may thus feel pressured to consent to the test.

3 PRIVACY & COMPULSORY HIV TESTING

Another limitation of the right to privacy has been introduced with the recent enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act¹⁷⁶ (hereafter: Sexual Offences Act/SOA), which makes provision for the compulsory HIV testing of alleged sexual and other offenders.¹⁷⁷ The following section will scrutinise whether the compulsory HIV testing provisions constitute a justifiable limitation of the right to privacy.

(a) Background

South Africa battles with an extremely high incidence of both rape and HIV/AIDS.¹⁷⁸ The concurrence of a high prevalence of sexual violence and of HIV/AIDS creates a dangerous situation where sexual offence victims,¹⁷⁹ in addition to the other traumatising consequences, face the risk of becoming infected with HIV. Compared to consensual sex, penetrative forms of coerced sex bear an increased risk of HIV transmission due to the use of force and sustained injuries.¹⁸⁰ Furthermore, in South Africa, women are often raped more than once and/or by more than one perpetrator, thus increasing the risk for injuries and facilitating HIV transmission.¹⁸¹ But given that not every rape leads to HIV transmission, the victim is left with uncertainty until

¹⁷⁶ See note 2.

¹⁷⁷ This approach has also been taken up in the United States, where many states enacted legislation allowing victims of sexual offences to apply for a compulsory HIV test of the rapist; K Smith 'Mandatory HIV testing for Convicted or Accused Sex Offenders: Towards a Model Scheme' (1998) 6 (52) *Buffalo Women's Law Journal* 53.

¹⁷⁸ In the year 2005/2006 there were 54.926 reported cases of rape; SAPS Crime Statistics 2006, available at http://www.saps.gov.za/statistics/reports/crimestats/2006/_pdf/provinces/rsa_total.pdf (last accessed 12 April 2007). There is, however, no doubt that these figures do not describe the real extent of the problem, because sexual offences are highly underreported; Shahana Rasool/K Vermaak/R Pharoa/A Louw/A Stavron *Violence Against Women — A National Survey* (2002) at 111; South African Police Service *Annual Report of the National Commissioner of the South African Police Service* (2003) at 36.

¹⁷⁹ According to the Sexual Offences Act 'victim' is defined in gender-neutral terms. Given that the vast majority of sexual offence victims are female, the term will be used in the feminine form, but it refers to both male and female victims.

¹⁸⁰ Furthermore, anal rape generally bears a higher risk for HIV transmission than vaginal rape, because of the probability of injuries to the victim.

¹⁸¹ Michelle Roland/Landon Myer/Roy Chuunga/Lorna Martin/Anastasia Maw/Thomas Coates/ Lynette Denny 'A Prospective Study of Post-exposure Prophylaxis Following Sexual Assault in South Africa', Paper presented at the 12th Conference on Retroviruses and Opportunistic Infections, February 2005. A further problem is that women who are disproportionately often victims of sexual assault are very vulnerable to HIV transmission because of their physiological features; Vetten/Bhana op cit note 84 at 5.

she can ascertain her HIV status through an HIV antibody test.¹⁸² This uncertainty can substantially increase the trauma experienced by the victim.

(b) *Overview of the provisions on compulsory HIV testing of alleged offenders in the Sexual Offences Act*

The Sexual Offences Act provides for the victim of a sexual offence or an interested person on her behalf to make an application for a compulsory HIV test of the alleged offender¹⁸³ (s 30 SOA). The application needs to be made at a police station.¹⁸⁴ An investigating officer can also apply for an HIV test of an alleged offender, if the testing appears necessary for investigating an offence (s 32 (1) SOA). In any case, the application has to be submitted to a magistrate. Where an application is made by or on behalf of the victim, the magistrate must make an order for the alleged offender to be tested for HIV at a designated health facility if he is satisfied that there is *prima facie* evidence that (1) a sexual offence has been committed against the victim by the alleged offender, (2) the victim may have been exposed to the bodily fluids of the alleged offender¹⁸⁵ and (3) no more than 90 calendar days have lapsed from the date on which it is alleged that the offence in question took place (s 31 (3) SOA).¹⁸⁶ Where an application is brought by an investigating officer, the magistrate must make an order for a compulsory HIV test of the alleged offender if he is satisfied that there is *prima facie* evidence that (1) the alleged offence has been committed by the alleged offender and (2) HIV testing

¹⁸² Certain HIV tests are able to pick up an HIV infection at an earlier stage. The latest antibody test (3rd generation ELISA plus p24) picks up antibodies approximately 14 days after initial infection (Personal Communication with Dr. Steve Andrews (MBChB (UCT); FCFP (SA); MPhil (Bioethics), Private Practitioner in HIV/AIDS Clinic, Cape Town). It is, however, unclear whether these tests are used nationally at public health clinics. Furthermore, polymerase chain reaction tests (PCR), which test for the virus itself, are able to pick up an infection from about ten days after seroconversion. These tests are, compared to antibody tests, very expensive, require special expertise for analysis and are not commonly used for HIV testing at public health facilities. For more information on HIV diagnostics, see Adrian J Puren 'HIV diagnostics' in S. S. Abdoel Karim/Q. Abdoel Karim (eds) *HIV/AIDS in South Africa* (2005) at 89.

¹⁸³ According to the Sexual Offences Act, both males and females may be the (alleged) offender of a sexual offence. Although the vast majority of offenders are male, and the term will be used in the masculine form, it refers to both male and female offenders.

¹⁸⁴ It can be made as soon as a charge has been laid, but at the latest 90 days after the offence has allegedly happened (s 30(1), (3) SOA).

¹⁸⁵ The term 'bodily fluids' refers to semen, vaginal fluids and blood (s 27 SOA). Mostly, an exposure to bodily fluids that carries a risk for transmission will occur during penetrative forms of a sexual offence, which under the new legislation constitute rape (ss 3, 1 SOA).

¹⁸⁶ A further prerequisite is that the alleged offender has not yet been tested for HIV on application by a police official (s 31(3)(ii) SOA). Interestingly, evidence by or on behalf of the offender may only be considered by the magistrate if to do so will not give rise to any substantial delay (s 31(2) SOA).

would appear to be necessary for purposes of investigating or prosecuting the offence (s 32(3) SOA).

Once an order is made, the alleged offender has to undergo HIV testing at a designated health facility.¹⁸⁷ The result of the test will be disclosed to the applicant (victim/person acting on her behalf; or investigating officer), to the alleged offender and where applicable to the prosecutor.¹⁸⁸

(c) Implications of compulsory HIV testing

The compulsory HIV testing provisions are problematic for a number of reasons. Unfortunately, it is beyond the scope of this article to comprehensively discuss concerns about their feasibility and utility as well as their implications for human rights other than privacy.¹⁸⁹

As set out earlier, testing a person's blood for HIV and disclosing the test result without his consent constitutes an infringement of the common law and the constitutional right to privacy.¹⁹⁰ It needs to be tested whether this infringement is justifiable under the common law and under the constitutional law, which require that conflicting interests be balanced.¹⁹¹

(1) Application by an investigating officer

Where an investigating officer applies for the test, the alleged offender's interest in privacy could be outweighed by the state's interest in the effective policing and prosecuting of crimes. Police investigations, including the collection of evidence, are the basis for the successful prosecution of crimes and thus constitute an essential prerequisite for the functioning of the

¹⁸⁷ Non-compliance with the order constitutes an offence (s 38(2) SOA).

¹⁸⁸ The prosecutor and any other person who needs to know the test results will be informed of the results if they are to be used in ensuing civil or criminal proceedings (s 37(1) SOA).

¹⁸⁹ The compulsory HIV testing process may violate the accused's right to a fair trial (s 35 Constitution), the right to freedom and security of the person (s 12 Constitution) and the right to procedural fairness (s 33 Constitution). Some of these issues were raised by respondents to the draft Compulsory HIV Testing Bill, which was later included in the SOA. See SALRC *Fourth Interim Report on Aspects of the Law relating to AIDS — Compulsory HIV Testing of Persons Arrested in Sexual Offence Cases* (2000) at 193–200. Also see Stefanie Roehrs 'Half-Hearted HIV-Related Services For Victims' § 8 at 175–197 in L Artz/D Smythe (eds) *Should We Consent? Rape Law Reform in South Africa* (in press). For a more detailed discussion, particularly around practical concerns, also see Stefanie Roehrs 'Implementing the Unfeasible — Compulsory HIV Testing for Alleged Sexual Offenders' (2007) 22 *Crime Quarterly* 27 at 30–33.

¹⁹⁰ The (less convincing) argument that the sexual offender may have forfeited his rights by committing the sexual offence is not applicable here because the person to be tested is an accused, not a convicted criminal.

¹⁹¹ For details about the balancing see note 135. According to s 36 of the Constitution, laws that limit a human right must observe two criteria: (1) a human right may only be limited by a law of general application; (2) this law must be reasonable and justifiable in an open and democratic society. The Sexual Offences Act certainly fulfils the first requirement. To establish whether the legislation fulfils the second requirement the factors listed in note 135 have to be taken into account.

criminal justice system. The ascertainment of bodily fluids may form an essential part of the investigation of a specific crime and may be necessary for its prosecution (eg blood tests in drunken driving cases). The police need to have the tools at hand to investigate serious crimes effectively in order to protect society from harm. It could therefore be argued that creating a mechanism for the police to obtain a blood sample of an alleged offender and have it tested for HIV is a reasonable limitation of privacy under the common law, because under the *boni mores* the interest in effective crime prevention and prosecution overrides the alleged offender's right to privacy. The same could be submitted in relation to the constitutional test: limiting the rights of the accused is justifiable because the limitation serves the important purpose of an effective criminal justice system.

However, this line of argument can easily be rebutted. The compulsory HIV testing provisions are unnecessary because the law already provides for blood tests, including HIV tests, for investigative and evidentiary purposes. Section 37 of the Criminal Procedure Act¹⁹² (CPA) states that any police official may take such steps as he or she deems necessary in order to ascertain whether the body of an accused has any 'characteristic' or 'distinguishing feature', or shows any 'condition'. The CPA allows the police to make an order for the taking of a blood sample to perform tests for identification purposes or to obtain evidence (s 37(1)(c), (2)(a) of the CPA). Where a police official is not allowed to order a blood test, a court before which criminal proceedings are pending may make such order if necessary (s 37(3) of the CPA). The fact that the CPA provisions were not drafted with HIV/AIDS testing in mind is irrelevant. What is important is that the provisions are phrased broadly enough to cover HIV tests.

The courts have found that s 37 of the CPA does not interfere with an alleged offender's constitutional rights.¹⁹³ Given that the new statutes replicate the provisions of the CPA, it could be contended that the new provisions are justifiable because they serve the same purpose as the CPA provisions. However, since the purpose is already fulfilled by the CPA, the provisions in the Sexual Offences Act are not *necessary* to achieve the purpose. According to Currie/De Waal¹⁹⁴ reasonableness requires the limitation of a right to serve at least *some* purpose. How can the compulsory HIV testing provisions serve a purpose when this purpose is, in fact, already

¹⁹² Criminal Procedure Act 51 of 1977.

¹⁹³ In *S v Huma and Another* the court declared that the taking of finger prints does not constitute a violation of a person's constitutional right to dignity, but *even if it did*, such violation would be justifiable; *S v Huma and Another* 1996 (1) SA 232 (W) 237 E–F. In *S v Orrie and Another* Bozelak J conceded that the involuntary taking of a blood sample for DNA profiling constituted both an invasion of the alleged offender's right to privacy and bodily security and integrity. However, to the extent that such testing is undertaken for use in criminal proceedings, the limitation of these rights is permitted to ensure that justice is done; *S v Orrie and Another* 2004 (3) SA 584 (C) 591 E–G.

¹⁹⁴ Currie/De Waal op cit note 7 § 14 at 179.

fulfilled? This view may, on the other hand, appear somewhat formalistic because the core of both laws is the same: strengthening the criminal justice system. One may therefore contest that the same aim cannot be considered reasonable concerning the existing CPA but unreasonable concerning the new legislation. In the end, there is no need to resolve this argument. Whether the provisions are regarded as unreasonable or simply as redundant, they are definitely *superfluous* to enabling proper policing and prosecutions.

(2) *Application by a victim*

With regard to an application by the victim, the limitation of the alleged offender's privacy would be justified if the victim's interests override those of the accused.¹⁹⁵ According to the legislation, the purpose of testing the alleged offender for HIV is to reduce the victim's trauma and to empower the victim 'to make informed medical, lifestyle and other personal decisions'.¹⁹⁶ Furthermore, the Sexual Offences Act suggests that the victim could use the test result as evidence in any ensuing civil proceedings as a result of the sexual offence'.¹⁹⁷ It will be shown that testing the alleged offender for HIV does not help the victim to make any of these decisions and will not be useful in ensuing civil proceedings.

(a) Trauma, medical and lifestyle decisions

Helping the victim to make 'medical decisions' refers mainly to the decision of whether or not to use post-exposure prophylaxis (PEP). PEP is a 28-day regimen of antiretroviral drugs, which may prevent the transmission of HIV. Other medical decisions may include whether to terminate an existing pregnancy or stop breastfeeding because of the risk of HIV infection for mother and child.

The decision whether or not to start PEP needs to be made *immediately* after the sexual offence and cannot wait for the outcome of the test. Although PEP is given to victims up to 72 hours after the sexual offence, the medication should be started as soon as possible after the exposure, preferably within a couple of hours.¹⁹⁸ It is highly unlikely — if not impossible — that the application will be made, a court order be issued, the alleged offender be notified and tested, and the victim be informed of the result within 72 hours, let alone a couple of hours. Testing the accused for HIV can therefore not facilitate the victim's decision on whether to start PEP.

¹⁹⁵ The limitation of the alleged offender's privacy must be reasonable according to the *boni mores* principle and must be justifiable under the limitation clause (s 36 Constitution).

¹⁹⁶ Section 34(a)(i) of the Sexual Offences Act.

¹⁹⁷ *Ibid.*

¹⁹⁸ United States Centers for Disease Control and Prevention 'Antiretroviral Post-Exposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States' (2005) 54 *Morbidity and Mortality Weekly Report* RR2:8; C Fong 'Post-exposure prophylaxis for HIV infection after sexual assault: When is it indicated?' (2001) 18 *Emergency Medicine Journal* 242 at 244.

However, the test result could possibly still be useful at a later stage. It could enable the victim to make medical decisions about stopping PEP or terminating an existing pregnancy, or 'lifestyle decisions' about the necessity of practising safer sex. Unfortunately, the test result cannot be used for making any of these decisions. As has been pointed out by experts,¹⁹⁹ the test result is unreliable due to the 'window period'. The window period refers to the first three to six, sometimes up to 12, weeks after the initial infection during which HIV antibody tests cannot detect antibodies to the virus in the blood.²⁰⁰ However, the risk of transmission is particularly high at this time because of a high viral load.²⁰¹ As a result, an alleged sexual offender who is in the window period will test HIV negative, despite being HIV positive and highly infectious. The test result may thus be unreliable. Therefore, the victim cannot rely on the test result for making medical and lifestyle decisions. The same uncertainty exists where an alleged offender tests HIV positive. An HIV-positive test result does not imply that the virus was transmitted during the sexual offence. The risk of transmission depends on a number of factors such as sustained injuries and the presence of blood and other sexually transmitted infections. To be on the safe side, the victim should continue to use PEP and practise safer sex despite any outcome of the test.

The uncertainty of the test result and the fact that the accused's status does not reflect the victim's status also imply that pregnancy-related decisions cannot be based on the result and that the test is unable to reduce the victim's trauma. Due to the prevalence of HIV/AIDS, the victim is faced with a number of incredibly difficult and traumatic decisions. Compulsory HIV testing however will not help the victim deal with the aftermath of the offence.

¹⁹⁹ This was already pointed out during the drafting of the provisions. Respondents with this view included the Acting Director of Public Prosecutions Venda High Court, the Society of Advocates of Natal, Mr Ronald Louw, Pretoria AIDS Training, Counselling and Information Centre (ATICC), Northern Province ATICC, the South African Prisoner's Organisation for Human Rights (SAPOHR), representatives of the SALRC's Sexual Offences Project Committee, and the AIDS Legal Network, see SALRC op cit note 189 at 197. Also see K C Goyer 'Compulsory HIV testing for alleged sexual offenders: victim empowerment or violation of rights' (2001) 11 (6) *AIDS Analysis Africa* 8; Stefanie Roehrs 'Compulsory HIV tests for sexual offenders' (2003) 8 *News & Views for Magistrates* 1; Stefanie Roehrs 'Positive or Negative? Compulsory HIV testing for alleged sexual offenders' (2007) 20 *Crime Quarterly* 34 at 36.

²⁰⁰ Antibody tests are the tests that are currently predominantly used in the South African public health system. They do not test for the virus, but for an immunological response to HIV. So called polymerase chain reaction tests (PCR) can identify HIV during the window period. But even these tests can only detect the virus from about seven to ten days after initial infection. As these tests are very expensive and highly sensitive and require laboratory facilities for analysis, the author assumes that these tests will not be used for the compulsory HIV tests of alleged sexual offenders. See note 182 for references.

²⁰¹ Goyer op cit note 199 at 8.

(b) Using the test result in civil proceedings

Another purpose of compulsory HIV testing is to provide the victim with evidence for ensuing civil proceedings. The legislation thereby suggests that the test result will help the victim claim damages for suffering and/or HIV/AIDS transmission resulting from the sexual offence. But the test result is unsuitable for this purpose.

Firstly, the test result neither proves that the sexual offence took place, nor that the alleged offender was infected with HIV at the time of the sexual offence. Instead, the test result may show, though not reliably, whether the alleged offender was infected with HIV *at the time of the test*. Proving that the alleged offender was HIV positive at the time of the offence will remain very difficult.

Secondly, an HIV-positive test result does not prove that the victim contracted HIV as a result of the sexual offence, even if this may have been the case. Biological evidence that one person was infected with the HIV-strain of another requires a special DNA test that is very expensive and can only be analysed by specialised pathologists at certain laboratories.²⁰² The victim would therefore still need to prove that she was HIV negative before the sexual offence and that the offence was likely to have been her only exposure to HIV. The HIV test itself would thus be of little relevance and assistance.

(c) Justifiability

In summary, it is submitted that compulsory HIV testing constitutes an unjustifiable limitation of privacy. The victim's interests do not outweigh the alleged offender's interest in privacy because the victim does not benefit from having the alleged offender tested. The relevant provisions in the Sexual Offences Act therefore violate the common law and the constitutional right to privacy.

(d) Practical concerns

Although not directly relevant to the foregoing discussion, it appears necessary to briefly reflect on a few practical concerns relating to compulsory HIV testing.²⁰³ Though envisioned as a 'victims' service', compulsory HIV testing may backfire and instead put victims at risk. The greatest danger is that the accused is tested for HIV during the window period and the victim relies on the HIV-negative test result for medical and lifestyle decisions. If for instance the victim decides to stop taking PEP and practising safer sex, she risks HIV infection for herself and her partner. Proper education around the

²⁰² Personal communication with Prof. Lorna J Martin (MB BCh (Wits), Dip For Med (SA) M Med Path (Forens), FC for Path (CMSA), Head of Division of Forensic Medicine and Toxicology, University of Cape Town.

²⁰³ As noted above, it is beyond the scope of this article to examine the feasibility of the provisions. See Roehrs *op cit* note 189.

implications of compulsory HIV testing is therefore vital.²⁰⁴ Other concerns relate to the criminalisation of victims and implementation challenges.²⁰⁵

4 CONCLUSION

With HIV/AIDS being the most stigmatised disease in modern history, the protection of privacy is crucial for the fulfilment of other human rights such as bodily and psychological integrity and equality. However, privacy is not an absolute right and an HIV-infected individual's privacy needs to be balanced with their sexual partner's right to bodily integrity. Current policies for HCP are unclear about which circumstances require an HCP to inform the sexual partner of his patient of his exposure to HIV, and whether such disclosure would be a justifiable limitation of the patient's privacy. The argument is made that such disclosure may constitute a justifiable limitation of privacy, but that there is no general legal duty for HCPs to warn their patients' partners. Given that partner notification programmes are difficult to implement and only reach a limited target group, they should not be introduced in South Africa. Instead of counteracting gender imbalances, these programmes have the potential to expose vulnerable women to (further) abuse, abandonment and violence. Partner notification schemes might also deter people from using voluntary counselling and testing services, thereby driving the epidemic further underground.

Finally, the analysis of the new statute on compulsory HIV testing of alleged offenders indicates that these provisions constitute an unjustifiable violation of the right to privacy. With regard to investigating officers, the provisions are redundant because blood tests for investigative purposes are already covered under previous statutory legislation. Balancing victims' and accuseds' rights shows that victims will not benefit from having the alleged offender tested for HIV. In the absence of such benefit, the limitation of the alleged offender's privacy appears unjustifiable.

²⁰⁴ The Sexual Offences Act and the policy framework for its implementation, however, lack provisions around counselling of the victim. According to the policies, the victim will be handed a notice explaining 'how to deal with the test results'. See s 33(1)(e)(i) of the Sexual Offences Act and the Department of Justice and Constitutional Development Criminal Law (Sexual Offences and Related Matters) Regulations, Government Gazette No. 31076, Regulation No. 5 (4) (b).

²⁰⁵ Conviction rates in rape cases are very low and therefore the majority of alleged offenders walk free after the criminal trial. After having had to undergo an HIV test the offender might try to get back at the victim by filing a civil claim for damages or laying a charge and have the victim prosecuted for making a 'malicious' application — an option provided for under the legislation (s 38(1)(a) SOA). Fortunately, the prosecution for a malicious application requires written authorisation by the relevant Director of Public Prosecutions (s 38(1)(c) SOA). See Human Rights Watch for conviction rates in sexual offences, Human Rights Watch, available at <http://www.hrw.org/english/docs/2003/12/31/safic7010.htm> (last accessed 2 February 2008). See Roehrs *op cit* note 189 for an in-depth discussion of practical challenges.